Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMP TODAY
PO BOX 27887
SALT LAKE CITY UT 84092

Respondent Name
FINANCIAL CASUALTY & SURETY INC

Carrier's Austin Representative Box
Box Number 28

MFDR Tracking Number
M4-12-2202-01

MFDR Date Received
FEBRUARY 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "When CompToday contacted Liberty Mutual regarding the denial it was explained to us that the denial for: Precertification/Authorization Absent was according to Official Disability Guidelines interpreted by the Bill Review Company. Section (a) of the rule referenced above clearly states: 'The closed formulary applies to all drugs that are prescribed for outpatient use for claims not subject to a certified network on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011. Liberty Mutual clearly has an obligation to pay the prescriptions billed as outline below on the following dates of service…"

Amount in Dispute: $27.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denied not per ODG guidelines."

Response Submitted by: Liberty Mutual Insurance Company, PO Box 4223, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2011	Prescription Medication	$27.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.530 sets out the requirements for use of the Closed Formulary for claims not subject to Certified Networks.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X484 – According to the Texas Division of Workers Compensation's rules effective May 1, 2007, all medical

treatment provided to Workers Compensation patients in the state of Texas must follow the official disability guidelines (ODG). The services provided are outside the ODG guidelines and no pre authorization was requested.

Issues

1. Did the requestor in this dispute dispense prescription medications to an injured worker with a date of injury before September 1, 2011?
2. Was the requestor reimbursed for the services provided?

Findings

1. Per 28 Texas Administrative Code §134.530(a) the closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011. The injured worker in this dispute has a date of injury prior to September 1, 2011; therefore, the denial by the insurance carrier is not supported.
2. The Division contacted Liberty Mutual in regards to their denial of no preauthorization in accordance with the ODG and requested they review the injured workers date of injury as it pertains to the closed formulary. Liberty Mutual submitted an EOB with check reference 0081984842 dated February 21, 2014 in the amount of $27.26 and an EOB with check reference 0081992417 dated March 5, 2014 in the amount of $2.50 for interest.

Conclusion

For the reasons stated above, the Division finds that the requestor has been reimbursed. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.